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Revision of Kentucky's Tuberculosis and Immunization Regulations

Tuberculosis

Kentucky's Administrative Regulation 902 KAR 2:090 "Tuberculosis testing" has been amended, effective November 22, 1996, to include detection, prevention and control measures. The following are highlights of these revisions:

In This Issue . . .

Revision of Kentucky's Tuberculosis and Immunization Regulations	1 & 4
Cardiovascular Disease The Leading Cause of Death Among Adult Kentuckians	2-3
Videoconference - Adult Immunization: Strategies That Work	4
Selected Reportable Diseases	5
Governor's Conference on the Future of Public Health in Kentucky	6

- ◆ The multiple puncture tuberculin skin test can no longer be used to meet the requirements for testing first-time enrollees in a public or private school.
- ◆ The tuberculin skin test of any child shall be interpreted, and when indicated treated in accordance with current recommendations of the American Thoracic Society and Centers for Disease Control and Prevention.
- ◆ Tuberculin skin test certificates may now be signed by an Advanced Registered Nurse Practitioner or by the local health department director or his/her designee.
- ◆ Drug susceptibility testing of initial isolates from clinical specimens obtained from any patient with active TB shall be performed by a licensed clinical laboratory or the state public health laboratory and repeated after three months for patient continuing to produce positive cultures.
- ◆ Local health departments may arrange for short-term hospitalization (invasive diagnostic procedures, respiratory isolation, or management of drug resistant disease) of TB patients identified by local health departments as being in exceptional circumstances.
- ◆ Local health departments may arrange for security measures to counter recalcitrant behavior.

Requests for copies of Kentucky's Administrative Regulation 902 KAR 2:090 "Tuberculosis detection, prevention, and control" may be obtained by contacting the state TB Control Program at (502) 564-4276.

Immunization Regulation see page 4.

Cardiovascular Disease

-The Leading Cause of Death among Adult Kentuckians-

Cardiovascular disease (CVD) is the leading cause of death among adult Kentuckians. Cardiovascular disease includes heart disease, stroke, and conditions affecting the blood vessels. It is responsible for more deaths per year than cancer, injuries, and infectious diseases combined. According to 1995 Vital Statistics data, 12,089 deaths due to heart disease and 2,509 deaths due to cerebrovascular disease occurred among Kentucky residents. Chronic conditions increase in both number and severity as people age. The high prevalence of cardiovascular conditions among the elderly, combined with a rapidly growing population of elderly people, is expected to dramatically increase the numbers of people with chronic care needs in the 21st century. Even if disability rates decline or disability becomes less severe, this will not completely compensate for the continued growth in absolute numbers of the elderly likely to require health services for CVD.

During the past two decades there has been a concentrated effort to reduce the risk of CVD through public education and research. Many clinical trials and studies have supported the conclusion that a great deal can be done to prevent CVD. Success of efforts to lower modifiable risk factors such as smoking, hypertension, hypercholesterolemia, overweight, and physical inactivity, together with improved technology and medical care is demonstrated by a decline in the age-adjusted mortality rate for heart disease and stroke in the past twenty years both nationally and in Kentucky. In fact, in Kentucky the age-adjusted mortality rate for heart disease has declined from 279.1 deaths per 100,000 in 1989 to 226.2 deaths per 100,000 in 1995, a decrease of 19%. The cerebrovascular disease mortality rate has declined by 20% in the same time period.

Data to track the trends of the risk factors related to CVD are available through the Behavioral Risk Factor Surveillance System (BRFSS). In 1988, the prevalence of current smokers among Kentucky adults was 34.2%; in 1994, 28.8%; and in 1995, 27.8% are current smokers. Of those, 39.3% reported they quit smoking

for at least one day during the last twelve months and 71.1% reported they smoke less than a half pack per day. Findings from the Harvard Medical School "Nurses' Study" indicate that women who smoke are nearly four times more likely to have a heart attack than women who never smoked, and the risk is even higher for heavy smokers.¹ Quitting removes about one-third of this excess risk in two years. Three-quarters of the excess risk of heart attack is eliminated in four years. Current women smokers are at three times the risk for stroke compared to women that have never smoked, but this excess risk completely disappears two to four years after quitting. According to the National Heart, Lung and Blood Institute (NHLBI), about 34.8% of students in grades 9 to 12 smoke. Children typically start smoking in grades 5 and 6.²

The 1995 BRFSS also indicates that 21.5% of the respondents reported that they had been told by a health professional that they had high blood pressure. There was a significant variation based on educational levels in those that self-reported high blood pressure. Those with less than a 9th grade education reported a prevalence of 45% and college graduates reported 12.6%. According to the NHLBI National High Blood Pressure Education Program, clinical trials documented that weight loss, reduced sodium intake, reduced alcohol consumption and exercise may be the most efficacious approaches to the primary prevention of hypertension.³ The prevalence of hypertension increases with age and is higher in blacks and males. One out of every four Americans has high blood pressure. The NHLBI reports that about 1% of children and adolescents have high blood pressure. No single causative mechanism has been identified in the pathology of hypertension. The cause of 90% of the cases of high blood pressure is not known. Poor adherence to long term treatment, both nonpharmacologic and pharmacologic, has been identified as the major reason for inadequate control of high blood pressure. Recent studies suggest that an appropriately planned health education program can significantly improve adherence to treatment, increase

adequate blood pressure control, and decrease hypertension-related morbidity and mortality.

High blood cholesterol is common. Despite recent controversy on the subject, there is considerable agreement among medical scientists that high blood cholesterol plays a causal role in coronary heart disease and that it is one of the three major risk factors that people can do something about. In the United States, people with a blood cholesterol of 240 mg/dl or higher have more than two times the risk of developing heart disease as do those with a level of under 200 mg/dl. About 25% of adults in the United States have blood cholesterol levels over 240 mg/dl and more than half of U.S. adults have levels over 200 mg/dl.⁴ Kentucky has established the target of 75% of Kentuckians knowing their cholesterol level by the year 2000. Data from the 1995 BRFSS indicate that 19% of adult Kentuckians have been told by a health professional that they had an elevated cholesterol level; however, only 64.8% had ever had their cholesterol level checked.

Smoking, high blood pressure, and high blood cholesterol are not the only factors that play a significant role in heart disease. Other factors such as overweight and physical inactivity also have an impact.

According to the 1995 BRFSS respondents, 29% of Kentucky's adult population reported being overweight (defined by Body Mass Index). This varied with education levels: individuals with less than a ninth grade education reported a prevalence of 35.8% compared to 25.9% for respondents who were college graduates. According to

the NHLBI, 11% (4.7 million) children age 6 to 17 are overweight--more than double the percentage of a decade ago.

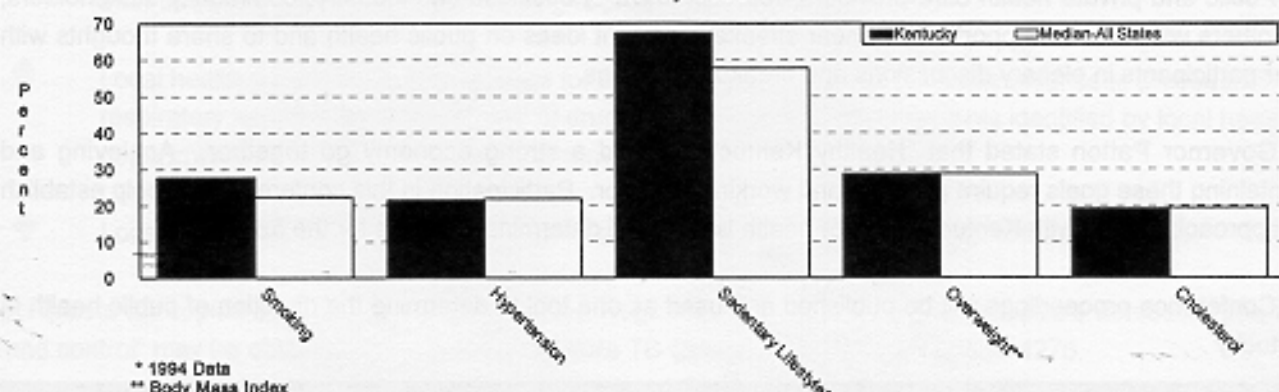
The 1994 BRFSS defined sedentary lifestyle as less than 20 minutes of physical activity three or fewer times a week. In 1994, 67.3% of adult Kentuckians reported being sedentary. It is interesting to note that the prevalence for individuals with an income of \$75,000 and over was 40.1% in comparison to 81.4% for individuals with an income of under \$10,000. NHLBI reports only about half of high school boys and a quarter of high school girls engage in a vigorous physical activity three or more times a week. Activity levels of girls are below those of boys and tend to decline with age.

Figure 1 compares Kentucky's 1995 BRFSS results for the five risk factors discussed to the median for all states.

It is possible to reduce the risk of cardiovascular disease without expensive and drastic medical treatment. Knowledge and understanding of factors which contribute to cardiovascular disease and methods to control these factors are the means for prevention and can be made available to everyone. If you have questions about risk factors and programs for their modification, contact the local health department in your area or the Adult Health Branch in the Division of Epidemiology at (502) 564-7996.

References available on request.

Figure 1. Percentages with Cardiovascular Risk Factors, BRFSS, Kentucky 1995



REGULATIONS (continued from page 1)**Immunization**

On January 15, 1997, a current, nationally recommended childhood immunization schedule was adopted by the Cabinet for Health Services as regulation in final form for Kentucky. The regulation requires that each child receive measles-mumps-rubella (MMR), diphtheria-tetanus-pertussis (DTP or DTaP), polio, *Hemophilus B*, and hepatitis B vaccines as appropriate for age, in order to attend school, preschool, day care, or other facilities that care for children in the Commonwealth.

The regulation was made possible by the passage of HB 588 (Immunizations, sponsored by Rep. Tom Burch) in the 1996 General Assembly. This statute added mumps, *Hemophilus B*, and hepatitis B to the list of diseases against which immunization is required, and further gave the Cabinet authority to add other diseases in the future, if recommended by national authorities. The statute contains a grace period of fourteen days for schools and preschools, and thirty days for other child care facilities, for

immunizations to be current. It is important to note that this grace period is from date of **ENTRY** to the facility, NOT from the date of inspection or review of records. Existing provisions for medical and religious exemptions were not changed.

The new regulation (902 KAR 2:060) lays out the schedule for required vaccines, according to the child's age in months or years. The immunization schedule is the same regardless of type of institution -- school, day care, or other facility. The requirements are in effect as of now, except for hepatitis B, which takes effect in 1998, and applies to children born on or after October 1, 1992, the approximate beginning date of Kentucky's universal infant hepatitis B immunization program.

Copies of the immunization regulation may be obtained from the Immunization Program at (502) 564-4478. Questions may be directed to the staff of the Program or to Dr. Reginald Finger at (502) 564-7243.

A Public Health Training Network Satellite Videoconference . . .



CDC
Presents:

Adult Immunization: Strategies That Work **April 24, 1997**

(For Jefferson County only) **8:00 10:30 AM & 11:00-1:30 PM - DST**

(Remainder of State) **11:00 AM - 1:30 PM DST**

Adult Immunization is a powerful disease preventive in search of advocates. Influenza and pneumococcal disease together are the fifth leading cause of all deaths among the elderly. Vaccine-preventable hepatitis B is second only to tobacco in causing cancer in adults. This live interactive satellite videoconference will demonstrate why you should be immunizing adults and, by featuring successful programs, how you can increase immunization levels in your private practice, managed care organization, hospital, long-term care facility, or public health clinic.

Target Audience - Physicians and others who provide immunizations for adults, as well as those who make immunization policy in managed care, hospital, long-term care, and public health settings.

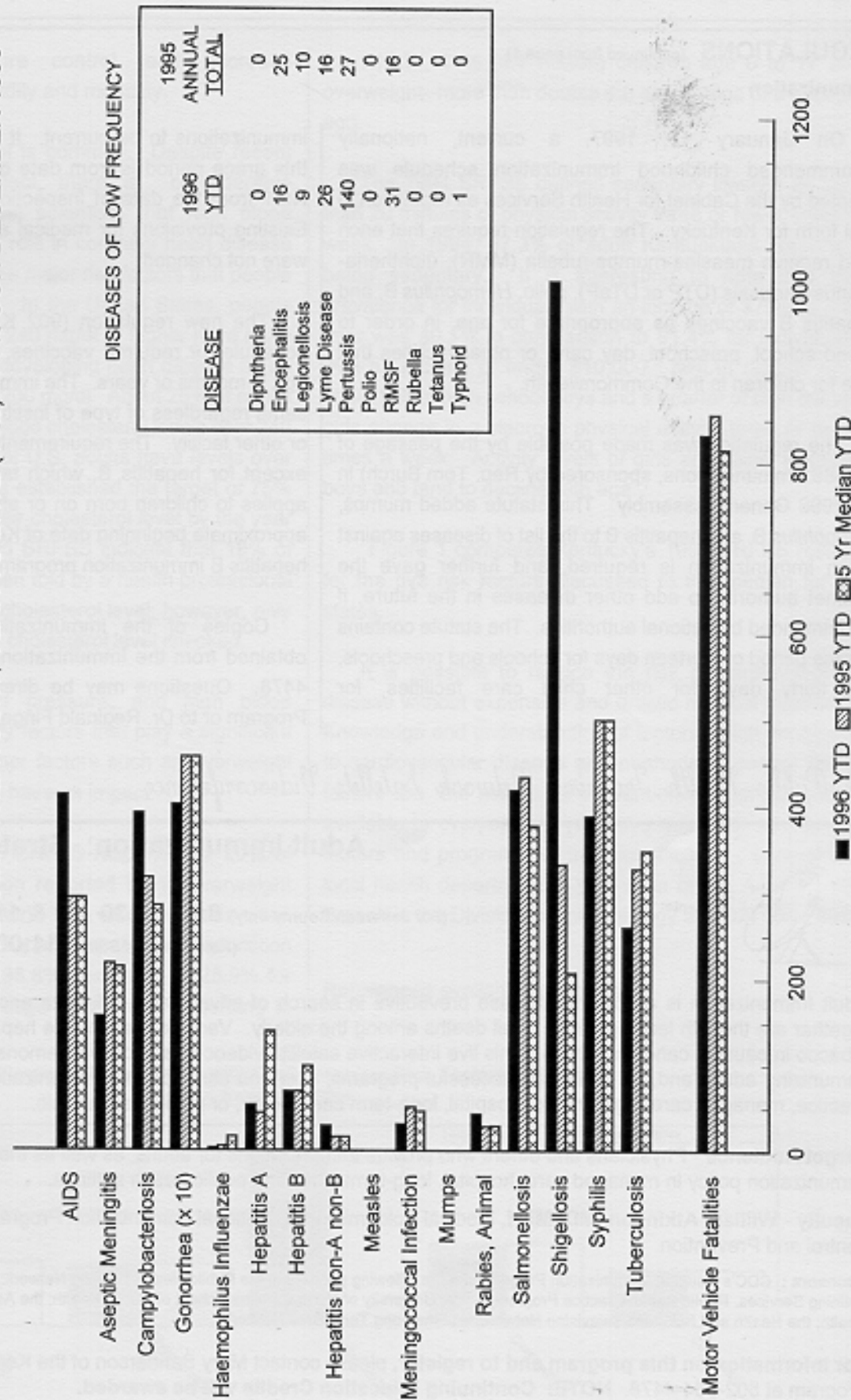
Faculty - William Atkinson, MD, MPH, Medical Epidemiologist, National Immunization Program, Centers for Disease Control and Prevention.

Sponsors : CDC's National Immunization Program and the following partners in the Public Health Training Network: CDC's Division of Media and Training Services, Public Health Practice Program Office; University of North Carolina School of Public Health; the Association of Schools of Public Health; the Health and Sciences Television Network; and the Long Term Care Network.

For information on this program and to register, please contact Mary Sanderson of the Kentucky Immunization Program at 502-564-4478. **NOTE: Continuing Education Credits will be awarded.**

— You Must Respond by March 24, 1997 —

CASES OF SELECTED REPORTABLE DISEASES IN KENTUCKY, YEAR TO DATE (YTD) THROUGH DECEMBER 1996



Disease numbers reflect only those cases which meet the surveillance definition.
Contributed by: Patricia Beeler, Surveillance & Investigations Branch.

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Upcoming Event

Governor's Conference on the Future of Public Health in Kentucky

Paul E. Patton, governor, Commonwealth of Kentucky, has announced March 11-13, 1997, for the *Governor's Conference on the Future of Public Health in Kentucky* at the Executive West Hotel in Louisville, Kentucky.

Public and private health care providers, representative of business and industry, community stakeholders, and others will have the opportunity to hear speakers present ideas on public health and to share thoughts with other participants in plenary discussions and breakout sessions.

Governor Patton stated that "Healthy Kentuckians and a strong economy go together. Achieving and maintaining these goals require planning and working together. Participation in this conference will help establish the approach to deal with Kentucky's major health issues and determine a course for the future."

Conference proceedings will be published and used as one tool to determine the direction of public health in Kentucky.